IMPACT OF INTEGRATED CHILD DEVELOPMENT SERVICES ON WOMEN AND CHILD DEVELOPMENT IN KANGRA DISTRICT OF HIMACHAL PRADESH

SYNOPSIS

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Introduction

Over a half of century, Integrated Child Development Service is working to improve the under-nutrition in the child with its vast infrastructure amounting routine analysis to guide the ongoing efforts to further improve its effectiveness in India . It is of the world's largest community-based outreach plan, Integrated Child Development Service is working to improve the under nutrition in the child with its vast infrastructure amounting routine analysis to guide the ongoing efforts to further improve its throughout effectiveness. Integrated Child Development Scheme provide basic essential services viz. nutrition, health and education for the proper development of the children in the age group upto six years and mothers in the age group of 15-45 years. Child malnutrition has long been a cause of worry for the national concern. Government of India sponsored vertical health initiatives has not been successful in reaching their intended audience. As far back as 1974, India has a clear national strategy on children. The introduction of a comprehensive multi-centric programme with a compact set of services was determined in accordance with this strategy. One of the most famous and flagship national human resource development projects of the Government of India was born as a result of this decision. As of October 2, 1975, a total of 33 blocks (4 rural, 18 urban, and 11 tribal) were part in the programme.

The scheme's major thrust is concentrated on the villages where more than 75% of the population resides. The show has a particular focus on the plight of those living in urban slums. Integrated Child Development Services for children are presently the most prominent child-related programme in existence. Under the ministry of social and women's welfare, the government of India signed off on the policy. As an activity, child development is a priority for the government of India. Changes in family life, such as lower rates of hunger, higher vaccination rates, and lower baby and child death rates, are anticipated to become more widespread. A high-quality piece of work for the development of human resources is an effective early act in this strategy. Supplemental nutrition, immunisation, health checks, and health education are all included in this programme, as are services for pregnant and breastfeeding women, teenage girls, and young women (10-18 years old), as well as informal education for children ages three to six. Anganwari Centers and Mini Anganwari Centers are in operation across the state as part of this initiative. There are Anganwari Centers in rural and urban regions. Under this programme, infants aged six months to six years old, expectant moms, nursing mothers, and low-income girls aged eleven to eighteen are all catered to.

More than a century of research has revealed a direct link between childhood trauma and the remainder of the person's life. Early experiences may have long-term consequences on one's learning, behavior, and health, according to Harvard University's Center on the Developing Child. These same experiences "*really go beneath the skin and into the body, with lifetime implications on adult physical and psychological health*." “Investing in early children is thus becoming more popular throughout the world, as nations see the value of doing so in the fight against inequality and in raising a new generation of healthy people. Prevention and extension are two of the goals of the ICDS programme. In Integrated Child Development Services, early childhood services are delivered simultaneously, although the health component is the most important one.. There is much more to Integrated Child Development Services than only the delivery of health services as a means of contributing to societal development via social service provision. Integrated Child Development Services has a limited influence on the nutritional status of mothers and children because of its restricted coverage. Universalization and restructuring had been advocated.

The emphasis should be on children under the age of three, pregnant women, and breastfeeding mothers while serving for 3-6 years. Even World Health Organization also recommends exclusive breastfeeding up to 6 months of age with continued breastfeeding along with appropriate complementary foods up to 2 years of age or longer. Mothers should be encouraged to breastfeed their children for at least 1 year. Breastfeeding for six months has been prioritized as the introduction of semisolid foods at six months of age. 28 percent of newborns in India are born underweight, which increases the risk of both illness and death. About 52 percent of child deaths in India are caused by malnutrition, which is also a major contributing factor in neonatal and child mortality. Stunted growth affects the development of 38 percent of children under the age of five, and thus contributes to cloud-based malnutrition. Inadequate nutrition, infections, and acceptable home care practices are all factors that contribute to a baby's low birth weight. All is not well with the ICDS programme, despite the fact that it is intended to be a successful one 60 percent of the AWC participants did not have access to a toilet, and 17 percent of those who did had a toilet that was deemed unacceptable. Most AWCS, especially those located in cities, lacked enough outdoor and indoor space for the use of Pre-School Education activity kits, which had a negative impact on the standard of PSE.

Concept of Integrated Child Development Services

Every nation that is considering making such investment may benefit from the ICDS's experience. The program's goal of providing high-quality health, nutrition, community education, and preschool education services to millions of disadvantaged people is exceptionally ambitious. It is expected to achieve this goal by the year 2020. Over the course of many decades, the plan has been beset by institutional problems. As the International Child Development System has grown, it has shown how difficult it is to scale up programmes that assist vulnerable children. Development of any country on social indices and economic success are heavily influenced by this most essential asset's physical, mental, and social well-being, as defined in the National Policy on Children, which is designed in the best interests of children. To guarantee children's survival and growth, the state is required to offer necessary services to them before and after birth as well as throughout the time of development, according to the 12th Five Year Plan Development Approach. The policy proposal also envisions the state providing the bare minimum of basic services, such as comprehensive health inputs, supplementary nutrition services to prevent deficiencies in children, pregnant women, and nursing mothers, nutritional education for mothers, and non-formal education for children and mothers. The age range should be progressively extended to include pre-school children so that, within a realistic time frame, all of the country's children are given with the circumstances necessary for their optimal development. As a result of these policies enshrined in the Integrated Child Development Services, the National Policy Resolution was adopted with the following key objectives: improving the nutritional and health status of children aged 0-6 years; laying the groundwork for the child's proper psychological, physical, and social development; reducing the incidence of mortality, morbidity, malnutrition, and school dropouts; and achieving effective coordination of policy and implementation among various stakeholders.

In its most fundamental premise, the programme is founded on the widespread agreement among academics, researchers, and practitioners that early childhood education and care are inextricably intertwined concerns that should be treated as a single entity. Taking into consideration the underlying assumption, the basic inputs under the ICDS programme include the provision of an integrated package of minimum basic services – health care (vaccination, referral, health check-up, nutrition and health education, nutritional supplementation, and early childhood education for 0-3 year olds and non-formal pre-school activities for 3-6 year olds) to benefit children from the

prenatal stage to the age of six, as well as pregnant and lactating mothers. Offering a bundle of services is largely founded on the premise that delivering diverse services in an integrated way would have a significant overall effect. The Integrated Child Development Services programme is the biggest community-based programme in the world, with over a million participants.

Health services in Himachal Pradesh

Currently, the Department of Health and Family Welfare in Himachal Pradesh is delivering curative, preventive, primitive, and rehabilitative services via an extensive network of 85 hospitals, 91 community health centres, 577 primary health centres, and 2,085 sub-centers. In order to give better health services to the population, the government is enhancing the current infrastructure by providing contemporary equipment, specialised services, and expanding the number of medical and paramedical staff members in medical facilities, among other initiatives.

In accordance with the National Health Mission (NHM), financial aid is offered to states in order to develop the public health system, including the renovation of existing facilities and the construction of new facilities. Under National Health Mission, high-focus states may spend up to 33 percent of their NHM money on infrastructure, while other states can spend up to 25 percent of their NHM funds on infrastructure. The following are the population conditions that must be met before public health facilities may be established: The number of sub centers in general regions is one for every 5,000 people, and one for every 3,000 people in difficult/tribal and mountainous areas. (b) Primary health care centres: one for every 30,000 people in general regions, and one for every 20,000 people in difficult/tribal and hilly areas, respectively. (c) Community health centres: one for every 1, 20,000 people in general regions, and one for every 80,000 people in difficult/tribal and mountainous areas; one for every 20,000 people in rural areas. The establishment of Sub-Health Centers (SHCs) on a 'time to care' basis on foot within 30 minutes of a hamlet has also been approved for selected districts in mountainous and arid regions, according to new criteria based on "time to care." It has also been agreed to strengthen sub-health facilities on a 'time to care' basis in chosen districts of hill states and desert regions, which are located within minutes walking distance of the habitations.

According to the Rural Health Statistics (RHS) 2017, the following is the status of public health facilities in the nation as of the 31st of March 2017: It is estimated that the nation has (a) 1, 56,231 Sub-Centers (SC), (b) 25,650 Primary Health Centers (PHC),

(c) 5,624 Community Health Centers (CHC), 1108 Sub-Divisional Hospitals, and 779 District Hospitals, among other facilities. There is a shortfall of 34961 SCs (20 percent), 6409 PHCs (22%), and 2168 CHCs (30 percent) throughout the nation, according to the Rural Health Statistics (RHS) for 2017.

First Referral Units (FRUs) provide comprehensive obstetric care services, including caesarean section, neonatal care, emergency care of sick children, full range of family planning services, treatment of STI/RTI safe abortion services, availability of blood storage unit and Referral transportation services included.

Table-1 Health Care Facilities in Himachal Pradesh (2001-2018)

Year	Medical Institutions as on 31st March 2018								
	Hospitals		Primary Health Centres	Community Health Centres	Sub Centres	Allopathic Dispensaries	Ayurvedic Dispensaries	Homoeopathic Dispensaries	Total
	Allopathic	Ayurvedic							
2001	50	23	304	65	2068	155	1112	14	3791
2002	50	23	303	66	2068	155	1118	14	3797
2003	50	24	441	66	2067	21	1112	14	3795
2004	50	25	438	66	2067	22	1118	14	3800
2005	50	25	439	66	2067	22	1118	14	3801
2006	50	25	439	66	2069	22	1105	14	3790
2007	51	25	443	71	2071	22	1105	14	3802
2008	52	26	449	73	2071	23	1109	14	3817
2009	52	28	449	73	2071	23	1105	14	3815
2010	52	28	449	73	2071	23	1105	14	3815
2011	52	28	453	77	2067	23	1105	14	3819
2012	53	28	472	76	2065	10	1109	14	3827
2013	53	30	474	78	2065	11	1108	14	3833
2014	61	30	489	78	2068	11	1109	14	3860
2015	64	30	500	78	2065	11	1113	14	3875
2016	74	31	518	79	2071	12	1112	14	3911
2017	75	32	538	89	2083	17	1151	14	3999

Source: i) Directorate of Health Services, H.P. ii) Directorate of Ayurvedic, H.P.

Table-1 shows that the number of hospitals increased from 73 in 2001 to 107 in 2016-17. The number of P.H.C's increased from 304 to 538 during the period of 2001 to 2017. The overall increases 3791 to 3999. The number of sub centers hospitals increased from 2068 in 2001 to 2083 in 2016-17. The number of Allopathic Dispensaries decreases from 155 to 17 during the period of 2001 to 2017. The number of Ayurvedic Dispensaries increased from 1112 to 1151 during the same period. The Homoeopathic Dispensaries still remains as 14. Number of Doctors per lakh population in Himachal Pradesh are 22.03.

Table-2 District wise and Number of Births Registered (2012-2015)

Year/ District	Number of Births Registered				
	Male	Female	Total	Rural	Urban
2012	66606	61005	127611	83558	44053
2013	66419	59987	126406	78213	48193

2014	58668	52563	111231	68487	42744
2015	60873	55043	115916	69990	45926
District-wise Births Registered					
Bilaspur	3646	3240	6886	4280	2606
Chamba	4751	4375	9126	7487	1639
Hamirpur	4178	3824	8002	2923	5079
Kangra	13312	11704	25016	18862	6154
Kinnaur	517	530	1047	1047	0
Kullu	3952	3878	7830	3871	3959
Lahaul-Spiti	197	203	400	400	0
Mandi	7085	6332	13417	7633	5784
Shimla	7983	7306	15289	6084	9205
Sirmaur	4335	3887	8222	5038	3184
Solan	5853	5389	11242	4835	6407
Una	5064	4375	9439	7530	1909

Source: Directorate of Health Services, H.P.

Table-2 shows the distribution of number of births registered of males and females in rural and urban areas of Himachal Pradesh. Number of births is important indicators that influence the size and growth of population. Table also shows the birth rate of Himachal Pradesh from the year 2012-2015 and all districts of Himachal Pradesh. By analysis the table it has been found that in the year 2012 the number of births registered is 127611 in total in which 66606, total male and 61005 total female with 83558 rural births and 44053 urban births registered. In the year 2013 the number of births registered is 126406 in total in which 66419, total male and 59987 total female with 78213 rural births and 48193 urban births registered.

In the year 2014 the number of births registered is 111231 in total in which 58668, total male and 52563 total female with 68487 rural births and 42744 urban births registered. In the year 2015 the number of births registered is 115916 in total in which 60873, total male and 55043 total female with 69990 rural births and 45926 urban births registered. It is observed from the above table that the number of births in Himachal Pradesh was showing downward trend from 2012 to 2014 with slight increase in 2015.

Table-3 Districts wise and Number of Infants Deaths Registered (2012-2015)

Year/ District	Number of Infants Deaths Registered				
	Male	Female	Total	Rural	Urban
2012	570	464	1034	537	497
2013	643	515	1158	641	517
2014	326	267	593	329	264
2015	459	339	798	431	367
District-wise Number of Infants Deaths Registered					
Bilaspur	17	10	27	10	17
Chamba	33	27	60	20	40
Hamirpur	18	20	38	11	27

Kangra	132	101	233	213	20
Kinnaur	0	0	0	0	0
Kullu	28	22	50	19	31
Lahaul-Spiti	0	0	0	0	0
Mandi	39	30	69	31	38
Shimla	108	81	189	54	135
Sirmaur	37	17	54	19	35
Solan	19	18	37	18	19
Una	28	13	41	36	5

Source: Directorate of Health Services, H.P.

Table-3 shows the distribution of infant mortality rate of Himachal Pradesh. Infant mortality rate is important indicator that influences the size and growth of population. The infant mortality rate was 38 in Himachal Pradesh and was 44 in India in the year 2011. Table 3 shows the number of infants deaths registered of Himachal Pradesh from the year 2012 to 2015 and all districts of Himachal Pradesh. By analysis the table it has been found that in the year 2012 the number of death registered is 1034 in total in which 570, total male and 464 total female with 537 rural deaths and 497 urban deaths registered. In the year 2013 the number of death registered is 1158 in total in which 643, total male and 515 total female with 641 rural deaths and 517 urban deaths registered. In the year 2014 the number of death registered is 593 in total in which 326, total male and 267 total female with 329 rural deaths and 264 urban deaths registered. In the year 2015 the number of death registered is 798 in total in which 459, total male and 399 total female with 431 rural deaths and 367 urban deaths registered. The number of death in Himachal Pradesh was showing downward trend from 2012 to 2014 with decrease in 2014 but slight increase in 2015.

Table-4 Birth and Death Rate in Himachal Pradesh (Per'000) (2001- 2015)

Year	Birth Rate	Death Rate
2001	21.2	7.1
2002	20.7	7.5
2003	20.6	7.1
2004	19.2	6.8
2005	20.0	6.9
2006	18.8	6.8
2007	17.4	7.1
2008	17.7	7.4
2009	17.2	7.2
2010	16.9	6.9
2011	16.5	6.7
2012	16.2	6.7
2013	16.0	6.7
2014	16.4	6.7
2015	16.3	6.6

Source: Sample Registration Bulletin, Govt. of India, 2015

Table 4 shows the distribution of birth rate and death rate of Himachal Pradesh from 2001 to 2015. Birth and death rate are important indicators that influence the size and growth of population. Crude birth rate in Himachal Pradesh was 16.5 in 2011 and was less as compared to India (21.8). Crude death rate was 6.7 in 2011 in Himachal Pradesh and it was (7.1) as compared to India. Birth rate and death rate in both in Himachal Pradesh are at the lower side as compared to all India in different years.

Table-5 Birth rate, death rate, and infant mortality rate in Himachal Pradesh and India from 2011 to 2015 are shown in the following table

Parameter	2011		2012		2013		2014		2015	
	H.P.	All India	H.P.	All India	H.P.	All India	H.P.	All India	H.P.	All India
Birth rate	16.5	21.8	16.2	21.6	16.0	21.4	16.4	21.0	16.3	20.8
Death rate	6.7	7.1	6.7	7.0	6.7	7.0	6.7	6.7	6.6	6.5
Infant Mortality rate	38	44	36	42	35	40	32	39	28	37

Source: SRS Bulletin, Registrar General of India, Health & Family Welfare Department, H.P.

The difference between birth rate and death rate gives the estimate of growth rate of population. It is very true that the rate of natural increase is the difference between birth and death rates. It measures the degree to which a population is growing. Since birth and death rates are measured as the number of births (or deaths) occurring per 1,000 population, the difference is divided by 10 to convert this rate into a percentage. The most encouraging and important fact is that both the birth and death rates in the state remained quite below than national average. The birth and death rate at both levels dwindled during 2011to 2015; however, nation experienced faster speed than state.

Utilization of Health Care Services

Health care facilities in Himachal Pradesh are more likely to be run by the state government than private providers. Surveys show that the state's population receives majority of its health care from the government sector. However, polls differ greatly on how much money is spent in the private sector and how much money is spent in the government sector.

Table- 6 Share of Health Care Use in India and Himachal Pradesh (%)

Survey	All-India	Himachal Pradesh

NSS 1995	17	36
NSS 2005	21	65
IHDS (2004-05)	17	56
NFHS-2(1998-99)Women's	42	64
NFHS-3(2005-2006) Women's	38	79

Source: State Statistical Abstract of H.P. 2012-13

Table-6 shows that NSS 2005, IHDS and NFHS-3 reveal that between 56 and 79% of service delivery is provided by government providers, with 82% hypothetically claiming that their family members go to government officials for health care if they are ill (see Table 6). The mid-1990s and the mid-2000s saw an upsurge in the utilization of government facilities. Over the course of a decade, public sector usage has risen from 36% to 66%, according to national polls conducted in 1995 and 2005. According to the National Family Health Study-3 (2005-06) survey, around 79 per cent of the respondents said that they had utilized government facilities, up to 64 per cent in the 1998-99 time periods. Overall, Himachal Pradesh residents utilize public healthcare facilities at a rate that is 40 percentage points greater than that of the rest of India, according to data from 2005. It's difficult to pinpoint the specific origin of the problem because of the scarcity of data from national surveys on the quality of health care and non-governmental health care institutions. The number of persons who seek medical attention from a government facility varies by district, ranging anywhere from 50% to 90%: The percentage of ill persons that go to government clinics for treatment, broken down by district (excluding hospitalizations). Government services seem to have seen an increase in demand between 1995 and 2005 in the majority of situations. Kinnaur, Mandi, Shimla, and Sirmaur all had usage rates of 90% in 2005, contrasted to Kangra, Una, Hamirpur, Solan, and Bilaspur, which had utilisation rates of between 50% and 70% of the population.

Table -7 Different Medical Institutions in Himachal Pradesh (2012-13)

S. No.	Institutions	Numbers
1	Medical Colleges	02
2	Dental Colleges	05
3	H.P. Medical Council	03
4	GNM Schools	33
5	B.Sc. Nursing Colleges	13

Source: State Statistical Abstract of H.P. 2012-13

Table-7 shows that According to the data, the state has two medical colleges and one government. The Dental College is one of five dental colleges in the private sector, and three councils of Himachal Pradesh are also in operation in addition to the Dental College. In addition, there are 33 General Nursing Midwifery (GNM) Schools and 13 Bachelor of Science in Nursing institutes operating in the state. The primary goal is to

improve the medical education system and to educate medical, paramedical, and nursing staff in order to monitor and coordinate the operations of the state's medical and dental services. The secondary goal is to improve the quality of the medical and dental services.

Meaning, Philosophy and Approach of ICDS

Preschool education, basic healthcare, vaccination, health checkup, and referral services are provided to children under the age of six and their mothers under the Integrated Child Development Services (ICDS) government programme in India. Integrated Child Development Services which has been around for more than 46 years, is essentially based on the concept of convergence, in which ICDS workers are trained to seek and get services from other government programmes conducted at the field level. These public health infrastructures are providing three of six Integrated Child Development Services categories: Immunization (immunisation), Health Check-Up (health screening), and Referral Services (referral services) under the Ministry of Health and Family Welfare. Health-related services including reproductive and child health care are being provided by the Indian government's National Rural Health Mission (NRHM), which is overseen by India's Ministry of Human and Family Welfare (MoHFW). Similarly, the Ministry of Minority Affairs is financing the development of AWCs in areas with a high concentration of minorities as part of the Multi-Sectoral Development Programme (MSDP). The Department of Elementary Education and Literacy, Ministry of Human Resource Development, Government of India, provides ongoing financial assistance for ICDS's Pre-School Education component, known as Sarva Shiksha Abhiyan (SSA).

Approximately 26 million children are born in India each year. According to the 2011 Census, 13% of the total population of the country is comprised of children ages 0 to 6. The National Health Mission's (NHM) National Child Health Program (NCHPP) aims to promote child survival and reduce newborn and under-five mortality via a wide range of initiatives. It is now well accepted that a mother's health and development as a teenager have a significant role in her ability to care for her kid, which in turn affects the child's survival. As a result, the national programme is following the idea of Continuum of Care, which emphasises care throughout important life stages in order to enhance child survival. Additionally, this method ensures that important services are provided at home, via community outreach, and at different health institutions at all levels (primary, first referral units, tertiary health care facilities). Pneumonia (16.9%), birth asphyxia & birth trauma (9%), other non-communicable diseases (7%), Diarrhoeal diseases (6.7%),

Ill defined or cause unknown (4.6%), Congenital anomalies (4%) and acute bacterial sepsis and severe infections (4.2%) are the most common causes of infant mortality in India according to the SRS reports (2010-13).

Introduction of ICDS in Himachal Pradesh

The ICDS Scheme in Pooh tribal block (Kinnaur Block) began as an experimental project in the state of Himachal Pradesh in 1975-76, and it was the first of its kind in the country. This initiative was carried out by 55 AWCs and 13 Mobile Centers around the country. These centres operate in a tough mountainous inaccessible inhabitable environment, and the AWW of the main nearby AWC travels to the outlying children and women in inaccessible locations to offer supplemental nourishment and check the development of the children in the center's care. The research for this study was carried out in the Kinnaur area of Himachal Pradesh. Four AWCs were chosen from a total of 55 applicants, namely Solan, Una, Kullu, and Kinnaur.

Challenges facing Integrated Child Development Services

The major difficulty about ICDS is that "the program has expanded faster than the institutional capacity to manage it," according to The World Bank. India is not the only country where those working with young children are paid less, mentoring and training than other teachers. A survey conducted in 2016 showed that one in five childhood workers in Australia were planning to quit their jobs in the next 12 months due to low pay, abundant paperwork and a sense of low valuation. A study conducted by researchers at the University of California in 2018, Berkley found that the "*system of preparing, supporting, and rewarding early educators in the United States remains largely ineffective, inefficient, and inequitable*."

The challenges with Integrated Child Development Services services remind us how insufficient investment in childcare professionals ends up costing the nation's children in the long run. Integrated Child Development Services pilot applications and other digital platforms are being tested by the Indian government to make data collecting easier for childcare professionals. Anganwadi and ASHA workers in India have just received a pay raise and additional social security benefits from Prime Minister Narendra Modi. The government has been criticised for not doing more to support and develop the huge number of people working in early childhood in the nation. In order to fill the void in ICDS services, commercial and nonprofit groups have stepped in. Early childhood care workers must be trained and retained; anganwadi facilities need to be upgraded;

wasteful expenditures must be addressed; and claims of rampant corruption that prompted ICDS must be dealt with. There has been a problem with the plan ever since it was first put forward. Unfortunately, children will continue to slip through the gaps until something is done about it. ICDS's Anganwadi Centers (AWCs) have the potential to improve service delivery. However, to do so, a new version of him must be created. It is estimated that there are 13.77 million Anganwadis in India based on official statistics. The reach of these institutions has unquestionably increased, but they must play a far more active role in fostering community development in their new locations. More than half of the Anganwadi centres that are now operational do not have drinking water or toilets. In 2015, NITI Aayog advised that Anganwadi centres have improved cleanliness and drinking water facilities, better energy supply, and basic medications. It was also recommended that these facilities be staffed with the necessary number of employees, all of whom would undergo regular training to keep their skills current.

In the absence of proper facilities in Anganwadis, beneficiaries of ICDS are forced to pay for services. Low-income families bear the brunt of the financial burden of privately managed institutions. It was found that enrolment in private nursery schools was one of the main reasons for non-adherence to ICDS services in coastal Karnataka. In addition, it said that the program's food supply needed to be upgraded in terms of quality. Anganwadi Workers (AWWs), ASHAs, and ANMs all working together is critical to the successful implementation of the ICDS programme. However, nothing has been done to enhance the career possibilities and service conditions of these front-line employees. States like Kerala, Telangana, and Tamil Nadu have done better than the national average. The Center's POSHAN Abhiyaan has made significant progress in the development of Anganwadi employees' capacities. Having a more robust process in place to perform frequent evaluations and correct knowledge gaps is essential. Program quality may also be improved using technology. Smart phones and tablets have been given to Anganwadi staff and their supervisors under government programmes. Take-home meals and additional nutrition services may be tracked using these apps. The information gathered should be used to make judgments on how to enhance the programme. Anganwadi facilities in Andhra Pradesh and Telangana have been geotagged to better offer services. The Anganwadi centres in Gujarat have been digitised and real-time data is being utilised to prevent stockouts. Anganwadi centres are in need of upgrading, according to the government. Anganwadi facilities around the nation will

be upgraded as part of the Saksham Anganwadi programme. States have the responsibility to take the reins.

Literature Review

A brief view of the exiting literature provides the significant insights and approaches for understanding questions centered on as to, what, how and why specific phenomenon occurred. Before proceeding further, it is right to take stock of available literature on the research problem. A plethora of literature, some of them very good quality books are available on Integrated Child Development Services. Some of major works have been reviewed as under:

Chaturvedi et al. (1989) described about the foundation for proper physical and psychological development of children is one of the stated objectives of Integrated Child Development Services Scheme, which is operational in India since 1975-76. This objective cannot be achieved unless a positive change in maternal attitude is accomplished. The present investigation was conducted in an oldest project area of India to assess this change using an adjacent Non-ICDS area as control. Majority of the mothers in both the areas were apathetic towards the health, education and play of their children. Nevertheless one encouraging trend was also observed. Significantly higher number of mothers in ICDS area had positive attitude in all the three variables in comparison to mothers in Non-ICDS area. It appears that ICDS Scheme has given the start but to have more acceptable answers, in depth investigations at national level are needed.

Tandon (1989) in his article highlighted that the ICDS be considered to function as a primary health care programme for preschool children (under 6 years old), pregnant women, and lactating mothers. The present study investigated the impact on the nutritional status of the target population after 3-5 years and after 8 years of ICDS interventions, compared with the nutritional status of non-ICDS (control) groups. The results showed that the ICDS nutrition intervention programmes achieved better coverage of the target population and led to a significant decline in malnutrition among preschool children in the ICDS population, compared with the non-ICDS groups that received nutrition, health care and education through separate programmes. This example may lead other developing countries to introduce integrated programmes with certain modifications to suit local conditions. International agencies and national governments should strive to bring about the integration of nutritional services with

primary health care and development programmes for children because of the good results in terms of child survival and child development.

Edmond (1990) represents a valuable source of information for anyone working with children and young people. This interdisciplinary core textbook looks at learning and development from birth to 19 years providing, an accessible introduction to the common areas of study across the many roles supporting learning and development in the young people's workforce. There is coverage of common themes and issues, and theory is closely integrated with practice throughout. The book focuses on the key areas of knowledge that all those working with children are required to study, and places them firmly in the context of working together to support children and young people.

Kakar (1992) attempted to study the children and the world around them are affected by which they develop mentally, physically etc. The present and future of children have been mentioned in this book.

Sharma and Gupta (1993) conducted an analysis with respect to the Integrated Child Development Services (ICDS) in India comprises health, nutrition, and education human resource development. The nutrition program in general aims to provide health and nutrition inputs to expectant mothers throughout the gestation period in order to prevent low birth weight babies; the nutrition supplement distribution has improved, but chronic malnutrition among pregnant mothers persists. The ICDS program provides regular health checkups, immunization, detection of malnutrition, treatment of diarrhea, and deworming of and for children. These services have contributed to improved health among children in ICDS areas. The infant mortality rate (IMR) of 71.3/1000 live births in 1992 in ICDS areas was found to be lower than national estimates in 1989. In ICDS projects more than 3 years old, IMR was found to be 84.5; further decline in IMR in 1990 were found in projects older than 5 years. Morbidity and mortality have been fund to be higher in non-ICDS areas, and declines have been observed in ICDS areas. The incidence of vaccine preventable diseases was not found to have declined in ICDS areas, in spite of increased immunization. ICDS provides anganwadi community workers (AWWs) and services through a network of Primary Health Centers and subcenters, which are not optimally used. However, when compared with non-ICDS areas, prenatal services are used by 71.9% of the pregnant population compared with 40% in a non-ICDS control group.

Lal and Sachar (1993) in their article critically analyze the India's Integrated Child Development Services (ICDS). Over the past 17 years, services have included minimum needs programs, integrated rural development and poverty alleviation, national health policy and education policy, universal immunization, and the development of women and children in rural areas. ICDS is sponsored 100% by the status and uniquely relies on the honorary anganwadi worker (AWW), who is a woman, recruited and chosen by the community, aged 21-45 years and middle-school educated. The AWW was responsibility for 2000 households or 1000 persons in rural areas and 700 persons in tribal areas. The AWW is crucial to the functioning of the program and receives an honorarium of Rs. 225-275/month for implementing the ICDs program; AWWs have helpers who are paid Rs. 110/month. Training over a 3-year period is conducted at the Bal Sevika Training Institute by the Indian Council of Child Welfare. Additional health personnel and their role and the number of persons/per area AWWS are responsible for, equipment, and functions are also described. The AWW is responsible for nonformal preschool education, organization of supplementary nutrition feeding, health and nutrition education of women and families, immunization of women and children, treatment and referral of common illnesses, growing monitoring, and community participation.

Ghosh (1995) revealed that the Integrated Child Development Services (ICDS) program was launched in India in 1975 in 33 blocks and 20 years later it covered 3654 blocks. The ICDS program has provided improved services, but it has failed to fully accomplish the intended goals, partly because of the lack of community participation. Supplementary nutrition was disrupted for over 90 days in 27% of AWCs. Often the food was not fit for consumption. The participation of pregnant and lactating women was also very low. Preschool education contributed a great deal to child development, but it was mainly limited to children 3-6 years of age leaving out the crucial age group of 1-3 years. Growth monitoring and promotion is a useful activity if it provides information on growth faltering; however, the involvement of the mothers was lacking in this program. Training and supervision was also lacking. The 300 odd centers where training was carried out were ill-equipped and ill-staffed. 20% of the child development project officer posts and 28% of supervisor posts were not filled. With regard to prevention of malnutrition, the ICDS managed it rather than prevented it because 60% of children become malnourished by the age of 6 months to 2 years. Centralized planning failed to fulfill special needs. On the other hand, the convergence of services resulted in better prenatal and immunization coverage in the ICDS blocks. In the non-ICDS area, severe

and moderate malnutrition was 8% and 22%, respectively, compared with 6% and 20% in ICDS children.

Kumar (1996) in his book that focus on Evaluation of Integrated Child Development Services program in Haryana, India.

George and Dahiya (1998) in a study conducted on Medical practitioner and 1022 women of Haryana found that there is no excess girl mortality in the early neonatal or late neonatal phase but there appears to be excess girl mortality in the post neonatal phase and girls are at risk of significantly greater mortality after the first year of life. The sex ratio at birth for all birth orders for recently born children are masculine, including the first order. Study also reveals that male babies are provided with more privileges by giving them safe hospital deliveries while female deliveries are confined to their homes.

Kapil and Pradhan (1999) in his article reviews that Integrated Child Development Services (ICDS) scheme is the largest national programme for the promotion of the mother and child health and their development in the world. The beneficiaries include children below 6 years, pregnant and lactating mothers, and other women in the age group of 15 to 44 years. The package of services provided by the ICDS scheme includes supplementary nutrition, immunization, health check-up, referral services, nutrition and health education, and pre-school education. The distribution of iron and folic acid tablets and megadose of vitamin A is also undertaken, to prevent iron deficiency anaemia and xerophthalmia respectively. The scheme services are rendered essentially through the Anganwadi worker (AWW) at a village centre called "Anganwadi". The ICDS had led to (i) reduction in prevalence of severe grades of malnutrition and (ii) better utilization of services of national nutritional anaemia prophylaxis programme and the national programme for prevention of nutritional blindness due to vitamin A deficiency by ICDS beneficiaries. The ICDS scheme is being modified continuously to strengthen the programme.

W.H.O (2002) explored that t here are two main versions available: Clinical Descriptions and Diagnostic Guidelines and Diagnostic Criteria for Research. The former provides clinical descriptions detailing the principal signs and symptoms of each disorder, together with other important but less specific associated features, as well as comprehensive guidelines for their diagnosis. The latter version is intended to help those researching specific disorders to maximize the homogeneity of study groups. To this end, it sets out criteria that allow the selection of individuals with clearly similar symptoms and other characteristics.

Perianayagam (2005) presented a paper based on NFHS I & II. The findings reveal that, the rise in sex ratio at birth was steeper in the northern region while the Western and Eastern regions showed moderate rise. The sex ratio at birth was higher in urban areas compared to rural areas in most of the Indian states. Sex ratio at last birth shows a steep rise in northern and western states and moderate to marginal increase in the remaining states, suggesting that modern technological tests such as sonogram, ultrasound and amniocentesis had been widely used for sex detection and consequent abortion of female foetuses. Study further found that the excess female child mortality was very high at ages 1-4, and was highest in Haryana (134%), followed by Punjab (81%) and Uttar Pradesh (70%) and a very high level of neglecting female children (25-45% shortfall compared to males) was observed in immunization coverage in most of the northern states.

Kennison and Goodman (2008) This book highlights the problems, dilemmas and challenges facing the child protection agencies in England and Wales and tackles a variety of areas where knowledge on child abuse is either limited or out-of-date. Raising awareness of social, demographic, situational and environmental risk factors that may lead to the harming of children, it also looks at difficult cultural issues that sometimes get in the way of protecting children. Any professional working in, or studying, child protection will find this book an essential read.

Mamata and Sharda (2009) This book deals with different initiative that has been taken though Integrated Child Development Services.

Saxena and Srivastava (2009) explained that India's excellent economic growth over the past two decades affected the nutritional levels of its children? The ICDS program, so far, includes a study of how successful it has been in reducing child malnutrition. The article discusses the flaws in the design of the ICDS, and suggests practical measures to improve its implementation. It argues that the basic nature of the ICDS scheme should be changed from center-based to outreach-based, with a focus on children below the age of two years. The daunting task of changing child-rearing practices and control and treatment of infectious diseases should be emphasized. The article argues against the provision of packaged food, as it is unpopular with young children and has led to corruption.

Rani (2010) in his book on Integrated Child Development Services. The research findings described in this book are highly useful to policy makers and top level executives of the scheme in analyzing the factors associated with job performance and

job expectations of Supervisors and to take appropriate action for improving the functions of their Supervisors who are the back bone of this welfare programme.

Grady (2011) This book explores ways of doing this through reflection and a child development approach. The reader is encouraged to make links between their own knowledge of children and young people's development and experiences of recent changes in service delivery to uncover the commonality of the language of child development.

Venugopal (2012) in this rights-based study of the ICDS program sponsored by the Council for Social Development, New Delhi, and Venugopal holds a mirror up to the way this flagship program of the Government of India is faring and highlights its serious unmet expectations in implementation. These include inadequate enrollment of pregnant women, nursing mothers, children and adolescent girls who have a right to the ICDS services; grave cases of nutrition interruptions over extended periods; questionable quality of nutrition supplied; compromised growth monitoring; failure of convergence in health services including immunization and provision of crucial nutrients; grave inadequacies in training that impact adversely pre-school education and thus children's right to education and adolescent girls; and gross inadequacies of infrastructure and exploitative conditions of service affecting the effectiveness of Anganwadi workers.

Mohesri (2013) conducted a study using a cross sectional descriptive design in the Keonjhar district of Orissa. Multistage sampling method was used. The Anganwadi supervisor, child development project officer and 5 beneficiaries were also chosen from each Anganwadi Center and interviewed with the help of a check list.

Nabanita (2013) stated in his study that in India, on one hand, is progressing in several sectors of development but so far as women and children are concerned, This book provides details about infant mortality, maternal mortality, malnutrition among children, high prevalence of anemia among children and women, high incidence of childhood diseases, declining sex ratio of population under six years, socio-economic status of women etc. in Indian context.

Jyothi (2014) explained that health and nutritional services can help to identify the biological and socio-cultural components of solutions to health and nutritional problems. Favorable health and nutritional policies and effective and equitable health and nutritional services are critical to the broader development goal of breaking the cycle of poverty, high fertility, poor health, low productivity and slow economic growth. Hence,

this book is designed to focus on health and nutritional services provided under Integrated Child Development Services scheme.

Ambert and Mandell (2014) The volumes in this series illustrate how social organization and private, emotional experience are different phases of the social process. They show the steps by which emotional experience is shaped by social structural, macro-level processes and how these processes are changed by experience.

Mohanty (2014) in his book provides details about Aganwadi and also explains Integrated Child Development Scheme well.

Chopra (2015) presents the existing policy and legal framework in India. The broad purpose of the book is to comprehensively discuss the roadblocks that the marginalized child in India faces, to understand the causes of these roadblocks and to evaluate government and civil society action for children in India. The book is also a comprehensive compendium on child rights in India from a child development perspective. It discusses the challenges that Indian children face for survival, development and education, especially if they are marginalized through disability, lack of care, and poverty. The major issues expounded by the author in relation to rights are infant and child survival, early child development, street and working children, children in conflict with law, children with disabilities, child trafficking and child sexual abuse.

Thakur et al. (2015) studied the ICDS scheme in District Mandi of Himachal Pradesh. The Integrated Child Development Services Scheme (ICDS) in which Anganwadi Centers (AWCs) are the focal point for delivery of services, has been considered as one of the largest and unique grass root level early childhood development programme to address health, nutrition and development needs of children, pregnant women, nursing mothers and adolescent age group girls.

Balarajan and Reich (2016) in his study applied Kingdon's theory of agenda setting to explore how the issue of child nutrition and reform of India's longstanding Integrated Child Development Services (ICDS) scheme—a key policy intervention to address child nutrition—failed to sustain the attention of national policymakers in recent years. We find that although favourable factors were operating in the problem, policy and politics streams to promote policy reform, these were not sufficient to harness the potential opportunity for reform, with several missed opportunities to move the reform process forward. The analysis suggests that more attention to the political economy of the policy process may help to enhance the political feasibility of future policy reform efforts for

ICDS policy, and may have lessons for complementary policy reform efforts to improve child nutrition in India.

Meena et al. (2017) This book deals with practical and methodological assessment of India's foremost nutrition program with the integration of qualitative aspects and Insightful evaluation of strengths and weaknesses for policy recommendations.

Tiwari (2017) This book is based on latest international recommendations and resources with an Indian perspective. This book is updated Hindi version of bestselling book "A to Z Baby Care "by renowned Child and newborn specialist. He has tried to solve most of the new moms' doubts and queries on this subject with scientific and evidence based answers .Clear, step by step instructions, according to baby's month by month , beginning from preparations for baby's arrival, guide you through every step of baby care.

Gay and Truman (2019) This book highlights a wide range of ways in which one can practice walking as research and the many ways in which this can be recorded, captured, translated and activated through relational interventions and events. The book is rich in scope, engaging with a wide range of walking methods and forms including: long walks on hiking trails, geological walks, sensory walks, sonic art walks, processions, orienteering races, protest and activist walks, walking tours, derives, peripatetic mapping, school-based walking projects, and propositional walks.

Tucke (2019) The book is a comprehensive text describing various aspects of research with classic examples and case studies. Research becomes meaningful with inclusion of empirical studies conducted in the Indian context. This book talks about different methodologies used in conducting research in different social Science disciplines and in the applied fields.

Brenner (2020) focuses on the interplay between sociology and survey methodology: what sociological theory and approaches can offer to survey research and vice versa. The volume starts with a focus on direct connections between sociological theories and their applications in survey research. It further presents cutting-edge, original research that applies the "sociological imagination" to substantive concerns important to sociologists, survey methodologists, and social scientists and includes issues such as health, immigration, race/ethnicity, gender and sexuality, and criminal justice.

Vepa and Viswanatham, (2021) This book provides empirical evidence on the crucial role of public provisioning of food, water, sanitation and health care in reducing undernutrition in women and children in India. The linkages are cogently explored and

connected to the Sustainable Development Goals. This volume provides also a focused discussion on wellbeing of women and children in India through the lens of agriculture, and public sector interventions for better health.

Santrock (2021) provides an overview of children's development, from biological beginnings through infancy and early childhood to adolescence by highlighting the connection among different aspects of development.

Mohapatra et al. (2021) focused on the Integrated Child Development Services (ICDS) scheme is the world's biggest and unique programme for nutrition and childcare, launched way back on 2 October 1975 by the Government of India. It is a centrally subsidised scheme implemented by states across the country for the benefit of children, especially for vulnerable groups. The scheme's main objective is to improve the health and nutritional condition of children below six years of age, along with pregnant women and lactating mothers. The objective of the study is to critically analyse functions of the ICDS Scheme in the state of Odisha about implementation and monitoring. The analysis was done with the help of secondary literature and available data from government documents. The opinion and experience of various stakeholders like Anganwadi workers, supervisors and other government staff have been analysed for this purpose. This article describes existing policies and procedures of food procurement, storing, supply, cooking, production and serving cycle under ICDS Scheme in Odisha. The recommendations of the study may help for future improvement of various thrust areas of the ICDS Scheme. The article brings out critical factors accountable for the efficient implementation of the ICDS programme. Further, the study evaluates the ICDS Scheme based on existing government guidelines to reach out to the masses in Odisha.

Research Gap Identification

With reference to the above review of the literature, we find that small scale research has been done on maternal and child health, Integrated Child Development Services and positive impact of ICDS services on child nutritional status especially with reference to Himachal Pradesh.

Research Question

- What is the origin of Integrated Child Development Services?
- What is the impact of Integrated Child Development Services on beneficiaries in Kangra District of Himachal Pradesh?

- What are the drawbacks in implementation of Integrated Child Development Services in Kangra District of Himachal Pradesh?
- What is the level of awareness among beneficiaries of Integrated Child Development Services in Kangra District of Himachal Pradesh?

Objectives

- To examine the origin of Integrated Child Development Services.
- To evaluate the impact of Integrated Child Development Services on beneficiaries in Kangra district of Himachal Pradesh.
- To identify the drawbacks in implementation of Integrated Child Development Services in Kangra district of Himachal Pradesh.
- To analyse the level of awareness among beneficiaries of Integrated Child Development Services in Kangra district of Himachal Pradesh.
- To make suggestions for improving child health and promoting integrated child development services in Kangra district of Himachal Pradesh.

Proposed Methodology

To conduct research through ethnography in the natural setting of an entire social community (Himachal Pradesh) so that the daily life and socio-culture here can be seen and experienced in the context of the holistic development of children. Here the focus of ethnographic studies is focused on how research on the development of children can be done in relation to the social status and social group of the children of Himachal Pradesh. Along with this, the study of Himachal Pradesh, Kangra district in the form of a case study is to be done in the context of Integrated Child Development. Interview of Subject experts, Local Administration will also be included mainly as a method of research. Apart from this, quantitative and qualitative research method will be used in the study. Since the overall objectives of the present study is to evaluate the availability of primary and secondary data of the study area and then to consider the optimum utilization. Quantitative data will be collected from a sample of questionnaires for birth rate and death rate, social and psychological survey each drawn from some selected districts (Kangra and Hamirpur) of Himachal Pradesh. Data will be classified and tabulated as per requirement of study. Some fieldwork and quantitative analysis, statistical analysis collected e.g. maps, graphs, and computer software excel tabulation etc. Primary data is collected by questionnaires and personal interviews and field visit. On the secondary data obtained from various sources.

ICDS scheme was first started in Himachal Pradesh as a pilot project in 1975-76 in Pooh tribal block and then this program was implemented through 55 Anganwadi centers and 13 mobile centers. These centers operate in a difficult mountainous inaccessible habitable area, and Anganwadi workers go to nearby main Anganwadi centers in inaccessible areas to provide missed children and women, supplement nutrition and oversee the development of children. Now it will be important to assess the working of the ICDS project in Himachal Pradesh especially in the large populated districts like Kangra and Hamirpur. The purpose of this study is to try to know the different communities living here and their needs. It is important to know the current status of possible measures to improve the ICDS service delivery system. How literate are all the Anganwadi workers of the project. Have they received proper training or not? What is the present condition of the children living in the inaccessible places to be affected due to corona? What is the current status of mobile Anganwadi centers in Himachal Pradesh, how far it has proved to be meaningful, etc., is the need of the hour. The study of children's nutrition, mental status, child delinquency, what is the enrollment ratio, how many children dropped out or did not go to school, etc. becomes important. What is the present condition of children and pregnant women? What is the status of iron, folic acid and vitamin A tablets etc. at health centers? What is the current study of CHC and health infrastructure, how much is there, etc? Knowing the level of improvement in the nutritional and health status of children in the age group of 0-6 years and identifying the appropriate psychological, physical and social development of the child, etc., proves the relevance of this study. By the way, research work has been done on many aspects related to ICD. But the research of districts like Kangra and Hamirpur in the form of case study and ethnography has not been done in my view, so the relevance of my research increases even more. Kangra is the largest district of Himachal Pradesh and implementation of Integrated Child Development Services is largest in Kangra district. It is also easy for research to visit.

Thesis Outline

Chapter-1 Introduction

First, the chapter will include a brief introduction of the evolution of the Initiatives for Integrated Child Development Services (ICDS) as an idea, concept and types of services. The chapter also includes objectives of the study, significance and relevance of the study, methodology and the limitations of the present study.

Chapter-2 literature Review

Initiatives for Integrated Child Development Services in International and Indian context. In this chapter, the researcher will describe literature review, significant theory, critical review, theoretical framework, empirical review or systematic review, research gaps, conceptual framework and, hypotheses. Researcher will also describe the International Mechanism for Integrated Child Development Services (ICDS). In which the provisions made by International organisations such as the United Nations and UNICEF in the context of ICDS and by its various bodies will be studied. How various international institutions like UNICEF, World Bank, WHO are working for this? The aspects taken for the development of women and children at the international level will be studied. A study related to the Declaration of the Rights of the Child / Geneva Declaration, identification of the rights and human rights of the child will be carried out. The Millennium Development Goals, Child Development and Global and National Scenario, steps taken by the Government of India in the context of ICDS will also be included.

Chapter-3 Materials and Methods In this chapter, the researcher will describe the research design chosen to frame the study includes qualitative as well as quantitative research, and uses semi-structured interviews as well as focus group discussions for data collection, as well as secondary assessments. The chapter also discusses the research design, strategy, design, methods, and the study hypothesis. Also justify this design by linking characteristics of the design as found in the literature.

Chapter-4: **Data Analysis**

(Women and Child development in modern scenario in the Context of Himachal Pradesh and Kangra District of Himachal Pradesh regarding ICDS (Socio-Economic sample households).

This chapter includes an assessment of the primary data collected through qualitative and quantitative measures, as well as inferential analysis of the semi-structured interviews and focuses group discussions conducted. The chapter also includes figures and graphs for better assessments of the results.

The concept, development and introduction of child and women development in Himachal Pradesh will be covered in this chapter. The study of the origin, development etc. of ICDS in the state will also be included. What are the initiatives taken by the state and central government for child development in Himachal Pradesh? What is the status of women and child development till now? How much has already been improved or

changed. The study of budget allocation and expenditure of central government and state government under ICDS scheme, expenditure on supplementary nutrition program in Himachal Pradesh etc. will also be the main focus of this chapter. Programs run by the Government of India and the Government of Himachal Pradesh related to icds and their success and failure will also be included. In addition, the work related to icds in the state will also include the study of some basic issues.

Study of the status and implications of ICDS and child rights in Kangra and Hamirpur, expansion of ICDS in these two districts and study of beneficiaries of ICDS will be included in this chapter. Presently services provided under ICDS, Administrative setup of ICDS in Kangra and Hamirpur, Growth rate of expenditure of ICDS in Kangra and Hamirpur, Age wise classification of Anganwadi worker, Marital status, Educational level, of Anganwadi workers, Enrolled in school Number of children in the family, occupation of father/husband, distance of Anganwadi primary school and primary health center from home, occupation of beneficiary's parents, monthly income of the family, number of members in the beneficiary's family, earners in the beneficiary's family A comprehensive study on many aspects like number of members etc. will be covered in this chapter.

Chapter-5 Results and Discussion

This chapter will cover the result and discussion of research.

Chapter-6 Summary and Conclusion

This chapter will be in the form of summary and conclusion based on present study. It will also contain the recommendation and suggestion of the study.

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CERTIFICATE
(SYNOPSIS APPROVAL CERTIFICATE)

This is to certify that the Synopsis/Revised Synopsis for M.Phil. Dissertation/Ph.D. Thesis titled, "**Impact of Integrated Child Development Services on Women and Child Development in Kangra District of Himachal Pradesh ",** submitted by **Ms. Manjula** to the Career Point University, Hamirpur (H.P.), India in partial fulfillment of the requirements for the degree of **DOCTOR OF PHILOSOPHY** in the Division/Department of Humanities and Social Science, School of Legal Studies and Social Science has been approved by the Research Advisory Committee (RAC) after an Oral Examination of the student on dated 10.03.2022.

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